CLINICAL DOCUMENTATION STRATEGIES

Strategy 1: Reduce regulatory burden around documentation requirements for patient visits.

Discouraging physicians from seeing volume, and instead making time for QUALITY outcomes by expanding the time they spend with patients is very tricky. By reducing the E/M CPT's for mostly level 1 and 2, you are in effect reducing income per patient seen. You are also encouraging evaluations based on less patient data reviewed. This can only continue to reward volume at cost to quality.

The FIRST visit, i.e. NEW patient visit is the most crucial for data gathering and medical evaluation. This NEW patient visit must be reimbursed in such a way as to promote the time with the patient, and the completeness of the patient data reviewed. Therefore, possibly keeping the New Visit CPT's at all 4 levels.

CMS CY 2019 Physician Fee Schedule final rule, the reimbursement is at an all-time low, and I cannot see how level 1 and 2 reimbursements are going to do anything except encourage bad behavior by lack of complete patient data reviewed, and promotion of volume by scheduling patients every 12 minutes (5/hour) which is what many large groups now require. There should be a complete data review of provider expenses on average, and coordinate this with the reimbursement. Otherwise, you will continue to have Physician Assistants, and Nurse Practitioners as your main providers, with medical reimbursement becoming as shabby as teacher salaries, without the benefit of summers off, and 20 year retirement benefits.

Strategy 2: Continue to partner with clinical stakeholders to encourage adoption of best practices related to documentation requirements.

REVIEW OF SYSTEMS needs to be located in the EMR with the past medical, surgical, family history. It is now embedded in the note templates are requires data mining of notes to find it. It is a system that all providers use and or review, and therefore should be located in the shared data portion of the chart. With specialists, the sections that apply can be presented for their specialty focused inspection, but any abnormals in the general medicine or other specialty domains should be displayed as well, such as a person with historic chest pain presenting with hearing loss.

The ROS should NOT be added to the diagnosis list except where it is a place holder complaint for an undiagnosed condition, such as "GIDDINESS and DIZZINESS" when a first encounter does not lead to a definitive diagnosis such as "Acute Viral Labyrinthitis". I have found nurses placing the ROS complaints into the diagnosis list of the patient ("chest pain, shortness of breath etc.") This must be addressed since it creates a long, long diagnosis list of complaints.

The **REVIEW OF SYSTEMS** can also be used as a **telemedicine tag or alert** for incoming data from a patient. If the patient is taking home EKG or blood sugar, the abnormal result should be triggered through the ROS, and the alert sent to that provider who owns that section of the ROS, like the cardiologist for an arrythmia.

The **CHIEF COMPLAINT** should be cross referenced with the ROS, in other words, either the patient highlights the complaint in the ROS, or the Chief Complaint automatically populates in the ROS.

Strategy 3: Leverage health IT to standardize data and processes around ordering services and related prior authorization processes.

The **1995/97 PHYSICAL EXAM** guidelines need to be desperately revised, and I have been trying to volunteer for a few years to help with this without success. As an excellent example, in Otolaryngology you are still technically required to do a mirror exam of the nasopharynx and also the

larynx on all patients with a complete exam. The reality is that we do fiberoptic exams on our patients, and probably most residents graduating after 1995 have absolutely NO skill or intention of doing this type of antique exam. I also believe that the bullets for non specialty exam components, like noting regular respiration, or lack of pedal edema could be made more streamline.

Again, the Physical Exam template should in the EMR "background" be a large standardized template, just like the Review Of Systems template, but the provider can choose which sections to address depending on their domain of interest, yet any previous abnormals should display by default, until dismissed as resolved.

When reviewing the ROS or PE on an established patient, the previous findings should populate automatically, and there should be the ability to review the previous positive findings with the option of labeling them as AGGRAVATED, UNCHANGED, IMPROVED or RESOLVED. By labeling RESOLVED, the complaint or physical finding should automatically reverse to a normal description.

Finally, as with my experience with an ancient yet wonderful software called DRSNotes©, you should have the option of a full audit note, for payors or malpractice, and more importantly a shorter positives-only note that is somewhat like a SOAP note, which comes to the point, and leaves out all the background noise.

ALLSCRIPTS has long had an annotated discussion area under each diagnosis, and about 2 years ago EPIC did the same. This area under the diagnosis is tremendously important when describing your reasoning and its complexity in coming to the diagnosis. It will irreversibly label the provider, date and time when completed. It allows a provider to instantly review a problem on follow up without having to find the previous note. But also, it allows another provider to instantly understand the patient's latest findings and progress without having to data mine previous notes. For instance, if I were to plan surgery for a diabetic patient, I could review the latest comment, or series of comments on their diabetes control but viewing the annotated comment(s) under the diagnosis Diabetes.

Common data elements, standardized templates

HEALTH IT USABILITY STRATEGIES

Strategy 1: Improve usability through better alignment of EHRs with clinical workflow; improve decision making and documentation tools.

The large software vendors are using **MEDCIN codes** as well as SNOMED CT and LOINC. Why do we always leave MEDCIN out of the discussion??????

Strategy 2: Promote user interface optimization in health IT that will improve the efficiency, experience, and end user satisfaction.

I think that **GUI Graphical User Interface** is an excellent tool for displaying data in a quick intuitive fashion. I also feel that a "moving" windows type of presentation, much like a **PREZI®** presentation would be fabulous. You could keep separate windows for past medical, surgical, family histories, as well as medications and allergies. You also could have separate windows for labs, for radiology as well. So you can have your Diagnosis List (Problem List) as your home window, but reach out and bring any section in for review, and then discard out of your home field when finished.

I also believe that you should have the option when billing for a surgery, to send that surgery automatically (if desired) to populate the PAST SURGICAL HISTORY. Some vendors claim that they have this in place, but I have yet to see it. If you frequently do for example, endoscopic laryngoscopy, it should not populate the PSH usually, since it is done with relative frequency. So the provider must make the decision to send the CPT billed to PSH.

Once you have a surgery in PAST SURGICAL HISTORY, a link should be established to the OPERATIVE NOTE, and another link to the PATHOLOGY REPORT for that procedure date and time. Columbia University did this successfully with ALLSCRIPTS, and I just had to look for the tiny icon link to bring me to the OP report or the pathology.

Strategy 3: Promote harmonization surrounding clinical content contained in health IT to reduce burden.

I have recently sat in on a webinar demonstrating 3 API's for collecting EMR data to alert the IT department of possible risks for clinical data in real time with the provider.

I believe that open API's for gathering chart data for authorizations with come soon, but the authorization requirements must become more standardized and templated.

Strategy 4: Improve health IT usability by promoting the importance of implementation decisions for clinician efficiency, satisfaction, and lowered burden.

Nothing to add at this time.

EHR REPORTING STRATEGIES

Strategy 1: Address program reporting and participation burdens by simplifying program requirements and incentivizing new approaches that are both easier and provide better value to clinicians.

In 2013 I switched my positions, from a faculty practice provider, to clinical coordinator for the Otolaryngology Clinic, and then back to private practice. I lost my Meaningful Use dollars that year due to the switches, with no way to reconcile the discrepancy. Especially while in private practice, as a lone provider, it was very difficult to bring in the denominators to very useful levels due to my small patient population.

Strategy 2: Leverage health IT functionality to reduce administrative and financial burdens associated with quality and EHR reporting programs.

I believe that many of the eCQM's can be picked up in the CPT's of the Problem List, or the billed out CPT's. But in addition, the SNOMED CT coding etc.. should trigger the smoking, or BMI abnormal parameters, and with AI work behind the charting to present the measures that may or are applicable for the visit. I had learned the PQRS codes that pertained to otitis media and sinusitis and billed them out with my E/M CPT codes, in order to have a tabulatable record at the time of reporting. Most providers in my Academy of Otolaryngology were unaware that this was possible.

Strategy 3: Improve the value and usability of electronic clinical quality measures while decreasing health care provider burden.

I believe that this is continuously evolving over time. The decline in oral antibiotics for otitis externa, and reduced CT scans for acute sinusitis have been invaluable. With the wave of in office scanning, and pressure to make more money, this was an excellent example of VALUE! Presently there is questioning of the efficacy of antibiotics in acute appendicitis, and this again is a fine example of how these measures will change, be added, and help medicine evolve.

PUBLIC HEALTH REPORTING STRATEGIES

Strategy 1: Increase adoption of electronic prescribing of controlled substances (EPCS) and retrieval of medication history from state PDMP through improved integration of health IT into provider workflow.

The state requirements for completing a tutorial on both prescribing of controlled substances, and well as opioid prescribing does give credit toward MIPS Improvement Activities. However, you must sign on to most of the state sites (I have done this in 3 states) with a blood sample, and security questions that I invariably fail, and this is JUST to check the state site for previous prescribed opioids. You then have significant hurdles to ePrescribe an opioid. This needs to be streamlined, and I feel that bringing in our **pharmacy colleagues** would be MOST beneficial.

Strategy 2: Inventory reporting requirements for federal health care and public health programs that rely on EHR data to reduce collection and reporting burden on clinicians. Focus on harmonizing requirements across federally funded programs that impact a critical mass of health care providers.

Nothing to add at this time.

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